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Tobacco cessation program implementation—from plans to reality: skill building workshop—group model

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The following article describes highlights from the skill building workshop "Program implementation—from plans to reality". This workshop was conducted by Sallie Dacey, Group Health Cooperative of Puget Sound, and Risé Krejci, Pacific Health Systems.

Group Health Cooperative of Puget Sound (GHC) is a not-for-profit, group model, consumer governed health maintenance organisation (HMO). GHC serves over 450 000 enrollees at 29 medical centres, two hospitals, and three specialty centres in the state of Washington, primarily in the Puget Sound area. The cooperative employs 900 physicians, more than 40% of whom are primary care providers.

GHC reorganised its quality implementation structure in the early 1990s into a framework called the "clinical roadmap". This population and evidence based approach was designed to identify and improve systematically key clinical processes, and then embed them into everyday care. Tobacco use was one of the first areas to receive such attention. In 1992, reduction of tobacco use in the adult population became GHC's primary prevention priority as well as one of the initial four key clinical roadmaps. Using the National Cancer Institute's recommendations as a base, GHC set the goal of decreasing tobacco prevalence to 12.5% by the year 2000. In support of this goal, intermediate process goals were set, including: (1) status identification of tobacco use on 95% of all charts; (2) chart documentation of intervention in at least 45% of identified smokers during their last clinical encounter; (3) increased participation in "Free & Clear", GHC's behavioural tobacco cessation program; and (4) achievement of less than 10% fair/poor rating in satisfaction surveys of patients who were offered individual support and counselling on tobacco use by their providers.

After more than a decade of implementing and regularly improving GHC's tobacco reduction program, these intermediate process goals have been met and GHC's tobacco prevalence has decreased from approximately 25% to 15% (significantly below the state of Washington's reported tobacco use) (fig 1). Through this process seven key lessons were identified that optimise the success of a system wide tobacco reduction program.

Support at every level is key

Support at all the different levels of the organisation, from the top leadership down, is critical. A successful program involves laying this groundwork. Endorsement from the chief executive officer, the quality structure leadership, the clinic manager, and the medical chief, as well as individual providers and their teams, must be gained. Gaining this support starts with creating a sound evidence based argument as to why the program is central to the health of the patient. Such an argument was made in our report "Decreasing tobacco use at GHC during the 1990s" (available upon request), which was generated in 1991 by GHC's Committee on Prevention. This report served as the basis for singling out tobacco use as GHC's chief prevention priority in the 1990s. Over the past 10 years, tobacco leaders have used this report to educate other GHC leaders at every level and to provide a basis for further data collection. This campaign gained the initial support of leadership and subsequently led to the integration of strategies to decrease tobacco use at all clinical levels. Ongoing support rests primarily on the regular dissemination of strong clinical evidence that disease burden is notably decreased with tobacco cessation and that programs such as GHC's do help patients stop using tobacco.

Keep it simple, offload time intensive tasks, change systems

A busy clinical setting is much more able to accommodate new tasks which are simple and time limited. Our program uses standardised tobacco chart stickers and vital sign stamps, and user friendly pamphlets and forms. Key tobacco pamphlets are regularly stocked in all primary care exam rooms. These publications include: the National Cancer Institute's pamphlet "Clearing the air", a 36 page booklet on how to quit smoking; the Washington State Health Department's four page pamphlet on second hand smoke "One of the best things you can do for your kids"; and our "Free & Clear" program's four page pamphlet which

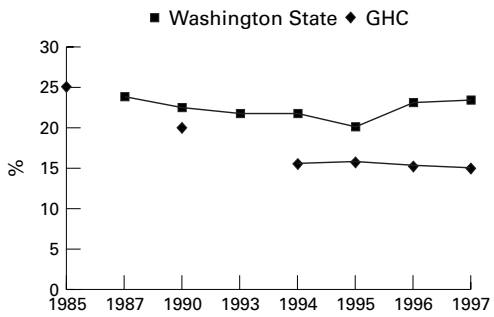

Figure 1 Adult smoking prevalence, 1985 to 1997.

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prominently displays its 1-800 registration telephone number along with an outline of how the program helps people quit smoking. Ready availability of the pamphlets, so that practitioners do not have to leave the exam room to retrieve them, has proved very important in getting this information to the patient. Tobacco questions have been embedded in all clinical well forms regularly used in primary care—including our adult health questionnaire, and our child, adolescent, pregnancy, and geriatrics well forms.

More recently, we have instituted diabetic and heart care computer based registries, both of which incorporate tobacco status and intervention as key clinical markers. Registered nurses (RNs) at every clinic have been trained to update these databases which facilitate visits with these patients. Forms have been created which contain an overview of these key patient data. In our large system we have learned the importance of new systems incorporating "old" priorities, and that vigilance is necessary to ensure this gets done. The continuing medical education (CME) opportunities at GHC were reviewed and modified to include topics on the contribution of tobacco use to disease burden. Additional lectures were developed to describe the programs GHC has in place to discourage smoking initiation and to quit using tobacco once started. These goals were included in the CME staffs' job descriptions with the responsibility to include these topics on an ongoing basis.

On another front, we quickly learned from provider feedback that many felt they did not have expertise in behavioural counselling, and had minimal time to engage in it. Our solution was to develop further a behavioural program, called "Free & Clear", that provided trained tobacco cessation specialists to perform this service. "Free & Clear" is a comprehensive telephone based behaviour modification program which uses cessation strategies recommended by the National Cancer Institute and the Agency for Health Care Policy and Research. Providers can easily refer patients to this program and patients can easily access it through a 1-800 line. "Free & Clear" provides an individualised program that includes assessment and staging, state of the art cognitive behaviour, self quitting and maintenance strategies, and a series of outbound telephone support interventions with a skilled cessation specialist. Patients are also evaluated for nicotine replacement therapy, and receive appropriate information and instruction along with mailed patches when appropriate. Recently, bupropion SR (Zyban; GlaxoWellcome) has been integrated into the program. "Free & Clear" links back to the participants' primary care providers by sending out letters when patients enroll, and by providing the practitioners with computerised letters to sign and send to their patients congratulating them on their quit attempts. "Free & Clear" is part of GHC's Center for Health Promotion and has a strong quality control/measurement system integrated into it.

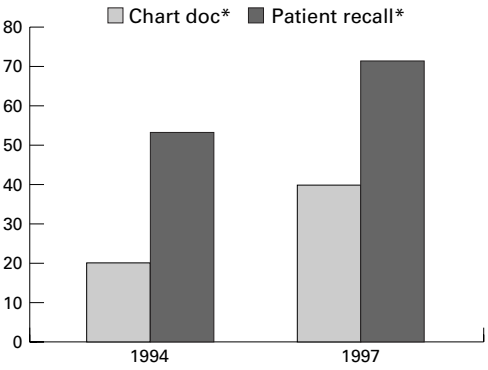

*Figure 2 Provider advice to smokers (*p < 0.05 for both).*

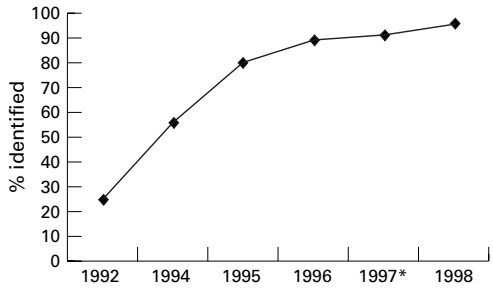

Figure 3 Primary care: tobacco status identification on all charts (> 85% in all 29 primary care clinics).*

Identify individuals at all levels accountable for measurable outcomes

It is critical that each member of the team understands his or her responsibility, as each carries out an essential function. The medical assistant asks the patient about tobacco use, puts the tobacco sticker on the chart, and uses the vital sign stamp. The provider uses this information to intervene with the patient (figs 2 and 3). The provider is also responsible for documenting this intervention in the chart note. The quality implementation team oversees the clinic's performance, identifies successes and problems, disseminates this information throughout the clinic, and brainstorms problem solving strategies. These responsibilities are written into the job descriptions of each of these groups.

The roadmap team reviews the data quarterly for the entire cooperative, assessing strengths and barriers to improving outcomes. This information is disseminated to clinic managers, chiefs, quality implementation leaders, and individual team members through reports, memos, and meetings. Outcome assessment targets are reviewed during the performance evaluations of the administrative leads (some members of the roadmap, clinic managers, and quality implementation team members), and salary is at risk if targets are not met.

Measure outcomes, evaluate the processes, and provide feedback

Measurement processes, carried out by dedicated individuals and groups, ensure that the process is being implemented and that best practices and problems are identified and addressed. Originally, individual clinical teams

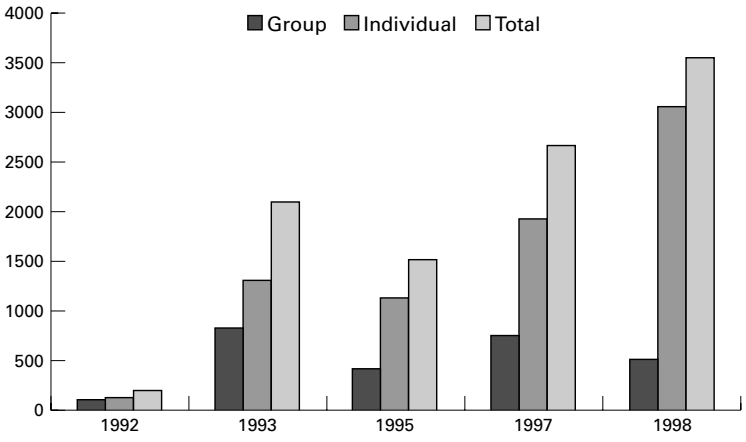

Figure 4 Participation in the "Free & Clear" program.

were responsible for their own chart audits. Subsequently, system wide sponsorship was achieved and resources were provided for quarterly chart audits of every provider. Currently, with the support of a Robert Wood Johnson Foundation grant, GHC is in the process of automating systems to identify tobacco users and to document intervention. These systems will allow ongoing measurement and feedback with the long range plan of using these data not only to feedback outcomes to providers and teams, but also to help tobacco users proactively stop using tobacco.

Audit results are transmitted to providers quarterly in the form of the "clinical practice report". This report includes key clinical information such as data on each provider's panel population and tobacco related key clinical outcomes. Providers are responsible for meeting organisationally defined targets. A quality committee, composed of physicians, the clinic manager, pharmacists, registered nurses, and a centrally supported quality implementation specialist, review the clinic's and individual provider's performance. The clinic's quality committee determines optimal ways to disseminate best practices and information in order to rectify problems.

Cover the cost of cessation programs/remove access barriers

Over the last decade, the "Free & Clear" program has removed barriers including cost and access, moving to a more easily accessed, primarily telephone based program. (Free & Clear offers both a telephone and a group option, but the telephone version is much more frequently used.) "Free & Clear" participation has increased from 190 patients in 1992 to over 3000 in 1997 (fig 4). Over the years the cost of the program to the patient has steadily declined. Recently, it became an entirely covered benefit.

Eliminating the cost to the patient was supported by a study done at GHC which revealed that more people participated in a full coverage group than in one that required co-payment. Importantly, the increased participation was not associated with a decline in the six month quit rate.[1] One year quit rates for the "Free & Clear" program have been maintained at approximately 30% over the last four years. These quit rates translate into one of the most cost effective preventive interventions in clinical medicine.

Establish ongoing centralised support/staffing and provide dedicated funding for this staff

Many programs have failed because centralised support was removed after the project was established. GHC's tobacco roadmap committee consists of a core group that meets twice monthly to oversee the cooperative's tobacco efforts. The core group includes the director of preventive services, a family practitioner, a health educator, and an administrative assistant. All of these individuals receive ongoing funding for this work. They are responsible for: (a) creating and updating the clinical guideline, which is published in paper form as well as on GHC's internet site; (b) organising all training—for example, training obstetrical providers to use the new obstetrical form; (c) responding to quarterly audits; and (d) setting the yearly targets for tobacco measures. The committee also meets twice yearly with a larger group which includes pharmacists, family practitioners, paediatricians, mental health workers, quality administrative leaders, and data experts who help direct and support tobacco work at GHC.

Start from where you are and keep at it!

Changing clinical behaviour and creating and achieving new clinical goals are long term processes. It takes years. Do not be disappointed in slow progress. Celebrate all victories, no matter how small they may be. Many obstacles to these changes exist. Understand your strengths and use them to move forward, working on each barrier as it arises.

GHC has been able to make great progress using these key lessons. We continue to explore new ways to optimise our tobacco cessation program, and have learned over and over that the above principles have been and will continue to be the foundation to continued successful implementation.

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1 Curry SJ, Grothaus LC, McAfee T, *et al*. Use and cost effectiveness of smoking cessation services under four insurance plans in a health maintenance organisation. *N Engl J Med* 1998;**339**:673–9.